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PHYSICIAN

APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION FOR THE BIENNIAL REGISTRATION PERIOD 2005- 2007

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, NV 89502

Date Received by Board

License No._____

File No._____

(For Board Use Only)

I hereby apply for status change or reinstatement to active status, and enclose the appropriate fee as indicated below:

_____CHANGE FROM INACTIVE TO ACTIVE STATUS	$ 600.00
_____REINSTATEMENT TO ACTIVE STATUS	$1,200.00
_____REINSTATEMENT TO INACTIVE STATUS	$ 600.00

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

PLEASE NOTE:

- **THIS *APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM IS THE FORM TO BE COMPLETED FOR CHANGE OF STATUS AND/OR REINSTATEMENT TO ACTIVE STATUS MEDICAL LICENSURE IN THE STATE OF NEVADA.**
- **YOUR STATUS WILL NOT BE CHANGED AND/OR YOU WILL NOT BE REINSTATED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM IS PUBLIC INFORMATION.**

PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration requires the submission of proof of completion of 40 hours of AMA Category 1 continuing medical education (CME), which includes 2 hours of CME in medical ethics and 20 hours of CME in your scope of practice or specialty **completed during the preceding 24-month time period of the date of your submission of this form**. Submit your proof of completion of CME with your completed ***APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION*** form. (See last page of this form for CME statement.)

2. If your name and/or address has changed from that printed on this form above, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

3. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name_____

Street_____

City_____County_____State_____Zip_____

Phone Number_____

4. Indicate below your primary and secondary scopes of practice using the following codes:

SCOPES OF PRACTICE CODES

1	ADDICTION MEDICINE	41	NEOPLASTIC DISEASES	81	PEDIATRIC, RHEUMATOLOGY
2	ADOLESCENT MEDICINE	42	NEPHROLOGY	82	PEDIATRIC, SURGERY
3	AEROSPACE MEDICINE	43	NEUROLOGY	83	PEDIATRIC, UROLOGY
4	ALLERGY	44	NEURO-OPHTHALMOLOGY	84	PEDIATRICS
5	ALLERGY/IMMUNOLOGY	45	NEUROPATHOLOGY	85	PHYSICAL MEDICINE/REHABILITATION
6	AMBULATORY MEDICINE	46	NEURORADIOLOGY	86	PREVENTIVE MEDICINE
7	ANESTHESIOLOGY	47	NON-CONVENTIONAL MEDICINE	87	PSYCHIATRY
8	BLOODBANKING	48	NUCLEAR MEDICINE	88	PSYCHOANALYSIS
9	BRONCO-ESOPHAGOLOGY	49	NUTRITION	89	PUBLIC HEALTH
10	CARDIOVASCULAR DISEASES	50	OBSTETRICS	90	PSYCHOMATIC MEDICINE
11	CATSCAN/ULTRASOUND	51	OBSTETRICS/GYNECOLOGY	91	PULMONARY DISEASES
12	CHILD NEUROLOGY	52	OCCUPATIONAL MEDICINE	92	RADIOLOGY
13	CHILD PSYCHIATRY	53	ONCOLOGY	93	RADIOLOGY, DIAGNOSTIC
14	CLINICAL PHARMACOLOGY	54	ONCOLOGY, GYNECOLOGICAL	94	RADIOLOGY, INTERVENTIONAL
15	CRITICAL CARE	55	ONCOLOGY, HEMATOLOGY	95	RADIOLOGY, NUCLEAR
16	DERMATOLOGY	56	ONCOLOGY, RADIATION	96	RADIOLOGY, THERAPEUTIC
17	DERMATOPATHOLOGY	57	ONCOLOGY, SURGICAL	97	RADIOLOGY, VASCULAR
18	EMERGENCY MEDICINE	58	OPHTHALMOLOGY	98	RHEUMATOLOGY
19	ENDOCRINOLOGY	59	OTOLARYNGOLOGY	99	RHINOLOGY
20	FAMILY PRACTICE	60	OTOLOGY	100	SLEEP DISORDERS
21	GASTROENTEROLOGY	61	PAIN MANAGEMENT	101	SPORTS MEDICINE
22	GENERAL PRACTICE	62	PATHOLOGY	102	SURGERY, ABDOMINAL
23	GERIATRIC PSYCHIATRY	63	PATHOLOGY, ANATOMIC	103	SURGERY, CARDIOTHORACIC
24	GERIATRICS	64	PATHOLOGY, CLINICAL	104	SURGERY, CARDIOVASCULAR
25	GYNECOLOGY	65	PATHOLOGY, FORENSIC	105	SURGERY, COLON/RECTAL
26	HAIR TRANSPLANTATION	66	PEDIATRIC, ALLERGY	106	SURGERY, GENERAL
27	HEMATOLOGY	67	PEDIATRIC, CARDIOLOGY	107	SURGERY, HAND
28	HOMEOPATHY	68	PEDIATRIC, CRITICAL CARE	108	SURGERY, HEAD/NECK
29	HYPNOSIS	69	PEDIATRIC, EMERGENCY MEDICINE	109	SURGERY, MAXILLOFACIAL
30	IMMUNOLOGY	70	PEDIATRIC, ENDOCRINOLOGY	110	SURGERY, NEUROLOGICAL
31	INFECTIOUS DISEASES	71	PEDIATRIC, GASTROENTEROLOGY	111	SURGERY, ORTHOPEDIC
32	INFERTILITY	72	PEDIATRIC, HEMATOLOGY/ONCOLOGY	112	SURGERY, PLASTIC
33	INTERNAL MEDICINE	73	PEDIATRIC, INFECTIOUS DISEASES	113	SURGERY, THORACIC
34	LARYNGOLOGY	74	PEDIATRIC, INTENSIVIST	114	SURGERY, TRANSPLANT
35	LEGAL MEDICINE	75	PEDIATRIC, NEPHROLOGY	115	SURGERY, TRAUMATIC
36	MATERNAL/FETAL MEDICINE	76	PEDIATRIC, NEUROLOGY	116	SURGERY, UROLOGIC
37	MEDICAL ACUPUNCTURE	77	PEDIATRIC, OPHTHALMOLOGY	117	SURGERY, VASCULAR
38	MEDICAL ETHICS	78	PEDIATRIC, PHYSIATRY	118	TOXICOLOGY
39	MEDICAL GENETICS	79	PEDIATRIC, PULMONARY	119	URGENT CARE
40	NEO/PERINATAL MEDICINE	80	PEDIATRIC, RADIOLOGY	120	UROLOGY

Code **Code**

Primary Scope of Practice ____________ **Secondary Scope of Practice** ____________

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All of the following questions refer to the preceding 24-month time period of the date of your submission of this form.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM.

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? _____Yes _____No

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? _____Yes _____No _____N/A

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? _____Yes_____No _____N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? _____Yes _____No_____N/A

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? _____Yes _____No

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not** considered **a minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? _____Yes _____No

7. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? _____Yes _____No

8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? _____Yes _____No

9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? _____Yes_____No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? _____Yes _____No

11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency <u>other than</u> the Nevada State Board of Medical Examiners? _____Yes _____No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _____Yes_____No

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (<u>Please Note</u>: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)

(If more space is needed, attach a separate sheet.)

OTHER STATES OF CURRENT OR PREVIOUS LICENSURE

List any and all licenses (including training licenses and permits) YOU HOLD OR HAVE HELD to practice medicine in any state, territory.

State/Territory	License #	Date of Issuance	Dates of Practice From (Mo./Yr.) To (Mo./Yr.)

(If more space is needed, please attach separate sheet.)

CHILD SUPPORT STATEMENT

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

Please place a check mark next to the following statement:

_____ I completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, **during the preceding 24-month time period of the date of my submission of this form**.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**
- **YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.**

BY SIGNING ON THE SIGNATURE LINE BELOW:

I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS *APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;

1) I UNDERSTAND THAT THIS *APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND

2) I UNDERSTAND THAT THIS *APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME); (b) PAYMENT OF THE APPROPRIATE FEE(S); AND (c) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).

_____ _____

Date Signature **(SIGNATURE STAMP UNACCEPTABLE)**